Ann E. Drouilhet, LICSW
40 Speen Street Suite 106
Framingham, MA 01701

NEW PATIENT INFORMATION

Date: _____

Patient Information:

Name_____
First MI Last

Address_____APT#_____Cell#_____

City_____ State____Zip_____Telephone # (___)_____Sex - M or F

Birthdate_____ Marital Status - M; S; D; W

Email:_____

Referred By:_____ Medications: _____

Physician: _____ Past Hospitalizations: _____

In the event of an emergency please contact:
Name: _____ *Phone:* _____ *Relationship:* _____

School Information:

School Name _____ Phone # _____ Grade _____

Address_____City_____ State____ Zip_____

Employment Information:
Employment: - F - P/T - Retired - Not Employed - ***(circle one)***
Employer_____ Phone (_____)_____-_____
Address_____City_____ State____ Zip_____

Family Members:

Name	DOB	Address & Phone (home & work)
1		
2		
3		
4		

Client Name_____

Insurance Plan Name_____

Address_____City _____State Phone _____

Subscriber Name_____("Same" if same as patient)

Subscriber Address_____("Same" if same as patient)

Relationship to Patient_____Subscriber DOB_____

Subscriber ID#_____Group#_____Policy#_____

Guarantor_____ Precertification #_____Co-Pay._____

Diagnosis code: _____

PATIENT or AUTHORIZED PERSON'S SIGNATURE REQUIREMENTS

Release of Information

I (patient, parent or guardian) authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed_____ Date_____
(Patient/authorized person)

Assignment of Benefits

I authorize payment of medical benefits to Ann Drouilhet, LICSW:

Signed_____ Date_____
(Patient/authorized person)

Confidentiality/Privacy Policies

I have received and understand my rights to protect my privacy and the confidentiality of services provided

Signed_____ Date_____
(Patient/authorized person)

Cancellation Policy

I request that you give me at least 24 hours notice if you must cancel an appointment. If you must cancel on short notice for unavoidable reasons, please call to let me know that you are not coming. I charge my usual fee for unnecessary cancellations or missed appointments. Please be aware that insurance companies will not pay for canceled or missed appointments.
I have read and understand the cancellation policy.

Signed_____ Date_____
(Patient/authorized person)